

Statement

of

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Before

THE NEW YORK STATE ASSEMBLY

COMMITTEE ON MENTAL HEALTH
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At the

HEARING ON ASSISTED OUTPATIENT TREATMENT, “ KENDRA’S LAW “

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For me, Kendra's Law is connected to a painful memory, to a sight that deeply disturbed the veteran homicide detectives who saw it: the corpse of a six-week-old baby girl who had never been fed by her mother.

The baby belonged to a woman with severe schizophrenia who, after giving birth, had been released from the hospital in Jamestown with a supply of anti-psychotic medications that she did not take. In the six weeks after her release, this woman was visited by a home health care aide, who had the door shut in her face. Because, legally, there was nothing else she could do when told to go away, the home health aide went away.

Meanwhile, because the woman hadn't shown up for her appointments at an outpatient clinic, the clinic simply closed her case, for noncompliance.

This incident happened before Kendra's Law. I was the director of the Mental Health Association in Chautauqua County, where Jamestown is located, at the time. We raised hell about it. We wanted to know who was the responsible for this woman "falling through the cracks." The Jamestown detectives were also interested in this question. Because of the circumstances, they honestly didn't know who to charge for the neglect that led to the baby's starvation. What eventually became evident was that no one was responsible. There was no law to assign such responsibility.

One would think that somehow the system wouldn't need such a law, that, given the pattern of the woman's psychosis, it would have naturally have made her a priority for support services in the community. After all, she had a lot of red flags, including being on probation as an accessory to murder. But back then this wasn't required.

Then, as now, the system had more cases than it could handle, but solely the law of supply and demand was in play. Because providers could close cases with impunity, the most difficult ones were dropped. Those individuals were more or less expected to wind up back in the hospital, if they were lucky.

It is likely that that baby girl would be alive today if her mother, who now is due to be released from prison, had been in Assisted Outpatient Treatment.

Do I think she should be in AOT if she is released back into the community? Hell yes! It would probably be the one critical thing to help her get a new start on life.

In terms of assigning responsibility and finding a way to serve those who most need help, Kendra's Law has been the lever for a huge paradigm shift in how we care for persons with severe mental illness. We in NAMI want that paradigm shift to continue. Others don't.

Today, you're probably going to hear a lot about what has happened in Chautauqua County, a mostly rural county that is as upstate as you can get. You will hear about what people believe needs to happen in order for Assisted Outpatient Treatment in such a place to be improved. One thing I and my fellow Chautauquans can tell you from firsthand experience is the fact that some rural upstate counties are providing little or no AOT should be considered an indication of failure.

Some of the recommendations you will hear tonight will be similar to recommendations in the NAMI New York State White Paper. Ideally, this whole hearing should be about how the effectiveness of this law could be improved. I don't expect this will be the case, however. I expect we're going to spend a good deal of time discussing whether the law should be gutted of the mechanism that makes it work, it's judicial authority, and explaining that, although they are few in number, the individuals who need this level of care actually exist.

The reason for this diversion is because there is a movement to stop the law led by individuals with a sincere, if misplaced, concern for human rights, whom I respect, and a consortium of mental health rehab organizations that I cannot respect on this issue. These organizations do skills acquisition, not symptom management. To benefit from their programs, one must be stable and have insight into one's illness. Yet their leaders are foolish enough to plug their own programs as an alternative to AOT.

Their leaders tend to dismiss "the medical model" and adhere to a philosophy of self-determination. Unfortunately, for those who need AOT, this approach is something of a cruel joke. As Edgar Rivera so eloquently put it in his testimony two weeks ago, those who need AOT don't need philosophy, they need help.

The anti-medical approach was the prevailing paradigm among community services before Kendra's Law, which is another major reason why the system had its head in the ground when it came to serving those who were most ill.

Today, Kendra's Law is still defamed by this group as a violation of human rights, ignoring the many legal protections in the law that err in favor of individual rights. The due process that must be undertaken to attain a court order is not easy, and it includes both a psychiatric evaluation and a civil court hearing to review the unique circumstances of each case. The court order is for a treatment plan that the patient must have already agreed to. It is much harder to get someone on AOT than it is to involuntarily hospitalize that person.

They declare that we should view every court order as a failure of the system. I view multiple hospitalizations, imprisonment, homelessness and death

as system failures, not the level of care that now has significant track record of reducing such failures, which is Assisted Outpatient Treatment.

It is frustrating that instead of debating how to improve the law's effectiveness, we wind up debating whether it should exist at all. Instead of discussing how to plot a better course, we have to go back and show, once again, that the earth is not flat.

If we must do this, then so be it. But let's decide at least these questions once and for all. We in NAMI New York State have concluded that the law must be made permanent. Only then will we be able to go to the next level and have the substantial discussion on increasing effectiveness that we should be having.

If this discussion must be postponed until then, chances for progress will be lost, but the law itself is sound enough that it will continue to save lives. Kendra's Law will never be perfect, but its fundamental framework is solid. It works and can work well when properly implemented. It has been proven to significantly reduce harm and improve quality of life for individuals, their families and their community.

Kendra's Law has been found to be a reliable vehicle to deliver the Assisted Outpatient Treatment level of care. The changes NAMI New York State recommends in its white paper pertain to improving the reliability of those who drive that vehicle through accountability measures, educating judges and providing financial incentives to provide AOT.

We also want to add some safety features, such as defining timeliness in investigations, getting back to families, making it practical for families to petition, putting procedures in place to transfer AOT from county to county, making the initial AOT period up to one year, enforcing standards and adding settlement agreements to the tools available to AOT programs. These measures would insure that even more lives are saved.

But the law itself so far is a good one. It is a law for which many are grateful. It is the best thing we have to depend on. Those who drafted it and championed it should be very proud.